MATUTECH, INC.

PO BOX 310069
NEW BRAUNFELS, TX 78131
PHONE: 800-929-9078
FAX: 800-570-9544

Notice of Independent Review Decision

DATE OF REVIEW: March 12, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Right cervical C5-C6, C6-C7 and C7-T1 facet injections with fluoroscopy and monitored anesthesia, CPT codes 64490, 64491, 64492, 01992

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
The physician providing this review is a Doctor of Medicine (M.D.). The reviewer is national board certified in Physical Medicine and Rehabilitation as well as Pain Medicine. The reviewer is a member of International Spinal Intervention Society and American Medical Association. The reviewer has been in active practice for ten years.

REVIEW OUTCOME
Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Office Visits (12/19/08 – 01/13/10)
- Diagnostics (11/20/09)
- Utilization review (01/26/10)
- TDI (03/03/10)

Consultants
- Diagnostics (11/20/09)
- Operative note (12/08/09)
- Office Visits (12/19/08 – 01/13/10)
- TDI (03/03/10)

ODG have been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a employed by who experienced sharp pain in the middle of his back on lifting a roll of aluminium metal weighing around 80 to 90 pounds on xx/xx/xx.

The next day, he was seen by D.C., who assessed thoracic strain, prescribed Motrin and allowed him to return to full duty work. The patient returned to work and functioned in more of a. In May 2009, he presented to Dr. with continued pain which had returned after five months. Examination revealed thoracic paraspinal muscle spasm and severe point tenderness with restricted active range of motion (ROM). Dr. diagnosed thoracic intervertebral disc syndrome and somatic dysfunction due to traumatic lifting event, placed the patient off work and recommended physical therapy (PT). The patient tried one month of conservative care but continued to complain of middle back pain with loss of spine ROM.

X-rays of the thoracic spine revealed degenerative scoliosis and kyphosis with osteopenia. Magnetic resonance imaging (MRI) of the thoracic spine appeared to show a space occupying lesion in the area of transition between cervical and thoracic spine. MRI of the cervical spine revealed: (1) A radial tear/fissure with diffuse bulging of the annulus at C7-T1. (2) Complete desiccation of the disc at C6-C7 with diffuse bulging of the annulus and mild spinal canal stenosis with mild narrowing of the proximal neural foramina bilaterally. (3) Diffuse broad-based protrusion of the disc at C5-C6 causing mass effect and moderate spinal canal stenosis. (4) Diffuse protrusion of the disc at C4-C5 causing mass effect, uncinate hypertrophy and narrowing of the proximal neural foramina bilaterally likely affecting the exiting nerve. (5) Minimal retrolisthesis of C3 on C4, spondylosis at C3-C4 with degenerative changes of the disc, asymmetrical bulging of the annulus and narrowing of the proximal neural foramina bilaterally.

Dr. stated that because of the lack of a thoracic disc protrusion, the patient might have a cervical disc provoking the long thoracic nerve radiating down the back or probably a muscular tear in the lower trapezius or under the trapezius in the erector spinae musculature. He referred the patient to an orthopedic surgeon.

M.D., an orthopedic surgeon, saw the patient for right scapular and right upper extremity pain. Examination revealed weakness in the ipsilateral upper extremity with associated stiffness and point tenderness in the right rhomboid at the upper medial scapula. Dr. diagnosed mechanical cervicalgia, rule out facet versus disc disease, right shoulder arthropathy and right suprascapular neuralgia. He performed right suprascapular nerve block.

Repeat MRI of the cervical spine showed: (1) A 5-mm broad-based posterior protrusion at the C3-C4 level, with small spondylitic component. (2) A 4-mm broad-based posterior protrusion at C4-C5. (3) A 3-mm broad-based spondylitic posterior protrusions at C5-C6 and C6-C7. (4) A 3-mm anterior subluxation of C7 on T1 as well as small posterior spondylitic protrusion at C7-T1. (5) A 2.5 mm broad-based posterior protrusion at T1-T2 and a 3-mm broad-based protrusion at T2-T3. (6) Multiple level bilateral cervical neural foraminal stenosis and multilevel cervical facet arthropathy. (7) Prominent multiple level cervical anterior spondylosis.

On January 13, 2010, Dr. noted the patient got 30% improvement in right shoulder and arm pain with the injection. The anesthetic response was positive. Pre-injection VAS was 6/10 and post injection VAS was 0/10. There was point tenderness in the right rhomboid at the upper medial scapula. Dr. reviewed MRI findings and diagnosed cervical facet arthropathy at right C5-C6, C6-C7 and C7-T1 and recommended proceeding with right cervical facet injections at these levels.

On January 21, 2010, the right cervical facet injections were denied with the following rationale: "*The patient's exam on January 13, 2010, indicated VAS score of 0/10 in the right shoulder and upper extremity improved from previous visit and 4-5/10 for cervical spine. Examination of the cervical spine was normal with normal bilateral C5-T1 pinprick, normal motor, reflexes and special exams. Point of maximum tenderness was right rhomboid upper medial scapula with normal range of motion without muscle spasms cervical spine. With this, exam findings are not consistent with facet mediated pain as outlined above. In addition, failure of conservative treatments to include PT and medications was not documented. Guidelines recommend only two levels and the request is for three. With this, medical necessity was not established. In addition, guidelines states that the use of IV sedation may be grounds to negate the results of a diagnostic block and should only be given in cases of extreme anxiety.*"

On February 22, 2010, the reconsideration was denied with the following rationale: *"This is a review for the request for an appeal for right cervical C5-C6, C6-C7 and C7-T1 facet injections with fluoroscopy monitor and anesthesia. The patient sustained an injury dated xx/xx/xx, as a result of a lifting injury. The latest follow-up dated January 13, 2010, showed that the patient complains of right suprascapular and right medial scapula pain and the current VAS score is 4-5/10. However, the medical records have not provided the documentation that this patient have indeed failed conservative management. This will include the physical therapy, medications and exercises. Also, the guidelines state that no more than two levels should be injected at any one time. Therefore, this request is not substantiated at this point of time."*

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

PATIENT WITH PREVIOUS CERVICAL FACET INJECTION WHICH WAS PERFORMED OUTSIDE ODG GUIDELINES (MORE THAN 2 LEVELS; NOT MEDIAL BRANCH TECHNIQUE; WHO HAD ESSENTIALLY NEGATIVE (30% RELIEF) RESULTS.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

IF YOU ARE NOT UTILIZING THE ODG GUIDELINES YOU MUST STATE WHY, PER TEXAS DEPARTMENT OF INSURANCE.

☒ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**